

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155423</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>04/04/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HAMMOND-WHITING CARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1000 114TH ST</b> <b>WHITING, IN 46394</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Post Survey Revisit (PSR) to Complaint IN00103864 investigated on 2/20/12.</p> <p>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/20/12</p> <p>This visit was done in conjunction with the investigation of Complaint IN00104301.</p> <p>Complaint IN00103864: Corrected</p> <p>Survey Dates: April 3 &amp; 4, 2012</p> <p>Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N.</p> <p>Census Bed Type: 74 SNF/NF 74 Total</p> <p>Census Payor Type: 29 Medicare 31 Medicaid 14 Other 74 Total</p> <p>Sample: 13</p> <p>Hammond Whiting Care Center was found to be in Compliance with 42 CFR Part 483 Subpart B</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 and 410 IAC 16.2 in regards to the PSR to Complaint IN00103864.  Quality review completed 4/9/12 Cathy Emswiller RN			{F 000}			